II. Background on Child Fatality Review Committees

In 1989, reporter Jane Hansen published a series of seven articles in the *Atlanta Journal and Constitution.* The series, entitled "Suffer the Children," detailed 51 deaths among children who were ostensibly under the protection of Georgia's child welfare system. Hansen reported an alarming lack of investigation into the deaths of these children that often led to labeling the causes of deaths as "accidental" or "natural", when they in fact were a result of child abuse and/or neglect.

Public outcry in response to Hansen's series prompted former Governor Joe Frank Harris to commission a task force to study the issue of unexpected deaths of children in Georgia. Because of a lack of consistency in investigative methods used by many state agencies, the Governor and others feared that child deaths attributed to Sudden Infant Death Syndrome or presumed to be accidental were actually homicides. The task force issued a report recommending, among other things, a uniform death investigation process throughout the state. The recommended process would include deaths from all unexplained and unexpected causes, not just those alleged from child abuse and neglect. The task force concluded that Georgia must develop a system to accurately identify and record the cause and manner of every child death that was unexpected or unexplained.

In 1990, the Georgia General Assembly mandated that every county take a proactive role in investigating and preventing deaths among children by establishing child fatality review committees. The Georgia Child Fatality Review Panel was created to provide direction, oversight, and training for each of the159 county Child Fatality Review Committees.

A. The Need for Child Fatality Review Committees

Information regarding the causes of death among Georgia's children and risk factors present in the lives of these children who died unexpectedly was initially limited. National studies, along with the reviews conducted by child fatality review committees, show information recorded on death certificates is often inaccurate or incomplete. This information, even when accurate, does not tell the surrounding circumstances leading to the death of a child.

Often preventative measures to save a child, or risk factors leading to the death of a child were unknown. In some circumstances, particularly in cases

of suspected child abuse or neglect, investigators were unable to determine if foul play contributed to the child's death.

Georgia's system for identifying and responding to child deaths was limited in the following ways:

- Georgia did not have a standardized procedure for the in-depth review of child deaths.
- Georgia did not have a consistent comprehensive system to collect information on the involvement of state and local agencies with children and their families, either before or after a child's death.
- Except for highly sensational cases, many child deaths went unnoticed in a community and consequently only were known to those individuals or agencies that had direct involvement with the deceased child.
- A great deal of misinformation, confusion, and disagreement regarding SIDS existed among coroners, law enforcement, health care providers, families, and the general public.
- Responsibility of local agencies for the investigation, delivery of services, and implementation of preventive actions were often unclear.

B. Legislation

Title 19, Chapter 15, Section 3, Official Code of Georgia Annotated, states that each county shall establish a local multidisciplinary, multi-agency Child Fatality Review Committee. The chief superior court judge of the circuit in which the county is located shall establish a child fatality review committee composed of, but not limited to, the following mandated members:

- Coroner or county Medical Examiner
- District Attorney
- Department of Family and Children's Services
- Juvenile Court
- Public Health
- Mental Health
- Law Enforcement

Child Fatality Review Committees in Georgia are charged with reviewing child deaths when those deaths are suspicious, unexpected, or unexplained. As part of the review process, particular emphasis has been placed on determining whether deaths were preventable, and if preventable, what actions should be taken to prevent similar deaths in the future. For your convenience, a copy of the relevant legislation is provided in Section XVI.